Cheshire East Safeguarding Children's Partnership

Child G

Local Child Safeguarding Practice Review

April 2021

This report will be published in line with statutory guidance. In order to preserve the anonymity, the author has:

Used initials to represent people

Refrained from using gender specific words for children

Cheshire East Local Safeguarding Practice Review Child G

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Anonymisation Key

Designation	**Referred to as:**
Subject Child	Child G
Mother of subject child	MG
Father of subject child	FG
Sibling	SG1
Sibling	SG2

Background to Review

This Local Practice Learning Review was commissioned by the Cheshire East Safeguarding Children's Partnership following the sad death of Child G, aged 3 months. Child G died in July 2020 as the result of an unexplained traumatic head injury. The child was born and died during the pandemic when the 'lockdown' restrictions were in place. Both Parents were in custody charged with murder when the review was conducted. The father was subsequently convicted of manslaughter and the mother was acquitted.

The decision to undertake this review was taken following a notification of Child G's death to the National Panel and the agreement of the rapid review.

The Rapid Review Meeting took place on 29.07.20 and has already been shared with the National Panel as set out in Working Together 2018.

The National Panel endorsed the Cheshire East Safeguarding Children Partnership decision to carry out a Local Safeguarding Children Practice Review.

Independence of the Review

The review author is an independent safeguarding consultant. She is a former Designated Nurse Safeguarding Children with extensive experience working with Local Safeguarding Boards and Safeguarding Partnerships. The author also has significant expertise in understanding the vulnerabilities of babies and the role of health services and partner agencies in promoting safety and well-being in all members of the family following the birth of a child.

Terms of reference

The review covers the period between Child G's mother's (MG) first presentation to services whilst pregnant with Child G to Child G's death in July 2020. Relevant historical information is also considered. The review is focussed on the agreed Key Lines of Enquiry where potential learning was identified.

Purpose and Focus of Review.

The purpose of the review is to identify key learning that may affect the way that practitioners and organisations work, both independently and together, which could make a positive difference for children and families in the future. This includes exploring and promoting identified examples of good practice.

Following a review of the multi-agency chronology, the minutes of the Rapid Review and the minutes of the Child Death Rapid Review, the Key Lines of Enquiry were agreed with Cheshire East Safeguarding Children's Partnership.

- Impact of parental history on agency decision making including the threshold for cross agency communication of relevant information.
- Impact on practice of family culture and ethnicity
- Assessment by adult facing services of impact of parental medication, stressors, and vulnerabilities on parenting
- Agency curiosity about the families wider social network and support for the family, particularly during the national Covid19 Pandemic strict lockdown.

- Research evidence that ICON is effective, widely disseminated to professionals in all agencies, and sits within a range of opportunities to give both parents access to support when they are stressed with a baby
- Assessment of baby feeding, weight gain and growth centile recording as possible stressors within the family.

Child G was born and died during the height of the Covid-19 Pandemic. Terms of reference will include an understanding of the additional stresses on the family due to the lock down and possible impact on the family in the way services were delivered during this time.

Organisations involved in the review

NHS Cheshire Clinical Commissioning Group (CCG)

Cheshire and Wirral Partnership NHS Foundation Trust (CWP)

Wirral NHS Community Provider Trust (0-19 Service)

GP Practice

Cheshire Police Constabulary

Cheshire East Early Help Service

Cheshire East NHS Trust

Cheshire East Children's Social Care

Context of Child G's life and death

MG and FG (Child G's father) lived together in an established relationship. They were the parents of SG1 aged 18 months. SG had been subject to a child in need plan at birth which had been closed prior to Child G's birth. During that period, the family had received family support services which had been well received and effective.

MG had a previous child SG2, born in 2008 with a different father. This child had been removed from their care and placed for adoption by a different local authority. The impact on parenting capacity at that time had been violence perpetrated by the father of that child to MG. At this time MG moved back to Cheshire East to be nearer to her extended family.

MG had a previous history of drug abuse. She had a mental health diagnosis of acute polymorphic psychotic disorder including symptoms of schizophrenia. In 2015, she had been informally detained under Section 2 and Section 3 of the Mental Health Act. She received extensive support from health services both during pregnancy and following the birth of Child G.

FG was from a traveller background.

There was no disclosure of domestic abuse within this relationship, no incidents reported to the police and no indication of safeguarding concerns raised by professionals involved with the family.

Child G was born and died during a period of strict lock-down due to the Covid-19 Pandemic. The relationship between MG, FG and their extended family is still not completely clear but there are indications that there was a growing rift within the family. This alongside the isolation from friends and normal activities imposed by the lock-down, including access to Early Help services, led to a situation of less social and family support than when SG1 was born.

During the ante-natal period MG was open and honest about her social and health history. She attended all appointments with her partner. The community mental health worker, health visitor, midwife, peri-natal mental health midwife and the GP communicated closely with each other and maintained frequent contact with the family throughout the ante-natal and post-natal period. During the national lock-down, some contact was via telephone or Skype, although midwifery services, maintained face to face contact throughout their involvement. This was good practice and allowed the family access to all the health services involved.

Following their first contact with MG, midwifery services checked with children's social care about their involvement with the family. A referral for early help services was considered but it was considered by midwifery that the family needs did not require this at this time. The GP had also discussed the case with the Named GP for Safeguarding Children. It was decided that a referral to children's social care was not required. The family did not require any additional services at that point.

MG's mental health was reported to have deteriorated on 10th June 2020, when Child G was six weeks old. It was reported that she was experiencing episodes of hallucination and hearing voices. There was excellent communication between the health visitor and the community mental health nurse which led to a decision to increase MG's medication. The impact of this was that it was reported to improve her mental health and the hallucinations subsided. On 25.06.20 the community mental health worker contacted MG by phone. MG requested an appointment away from the family home. This was arranged at the clinic premises. MG was distressed at this meeting, reporting that her mental health was deteriorating, her extended family was unhelpful and that things had been difficult at home with FG. The community mental health worker communicated with the psychiatrist and other health professionals. MG's medication was adjusted, and enhanced support put in place. MG's mental health appeared to improve.

On the 22.07.20 the ambulance service was called to the family home following a report of cardiac arrest. It arrived at 05.02. There was an initial delay in gaining access to the home as the door was not opened. Child G was treated and taken immediately to Hospital. Parents reported that MG had fed the baby at about 11pm. She woke again at 3 a.m. and on this occasion only took about 20mls of milk. The baby had 'not looked right' and FG alerted MG, calling the ambulance service just before 5 a.m.

Following admission to the local hospital a CT scan was undertaken which identified a bleed on the brain. The results were suggestive that Child G had been shaken and was unlikely to survive.

Child G was transferred to Manchester Children's Hospital. Further X-rays indicated old and new fractures to her ribs. A brain stem examination was conducted by two doctors on the 23.07.20 and Child G sadly died at 16.09.

Child G's sibling SG1 had a full child protection medical, and no injuries were identified. They were made subject to an Interim Care Order and placed with foster carers.

Police interviewed both parents at the time and the incident was unexplained. At a subsequent interview with the police, they were both arrested and charged with murder.

Analysis of Key Lines of Enquiry

Child G and the family received a good standard of care from the professionals involved. The family engaged with all health professionals and were pro-active in seeking help. During Child G's life, the family had at least weekly contact with a health professional, much of this being face to face during

a difficult period of strict lock-down. Professionals communicated well with each other, to meet the family's needs. No safeguarding concerns were identified at any time, but services recognised the potential vulnerabilities for the family and sought to prioritise the care and support they received.

The analysis of the key lines of enquiry was undertaken through a review of the multi-agency chronology, the minutes of the Rapid Review Meeting and through a meeting with professionals and their managers/safeguarding leads. Attendees at this meeting were prepared in advance by being provided with a summary of the case, the Key Lines of Enquiry, and the reasons for and outcomes expected from the meeting. They were also provided with the opportunity to speak to the independent reviewer if they had any concerns or questions regarding their role within the meeting.

The meeting was, of necessity, conducted virtually, through the forum of MS Teams, to comply with Covid-19 national restrictions. Although this worked reasonably well, some attendees found it difficult to maintain a constant internet connection.

1.Impact of parental history on agency decision making including cross agency communication of this.

Both FG and MG had complex histories. MG had been a victim of serious domestic abuse in three previous relationships. She had a history of mental health disorders and historical drug misuse. This history was known to health practitioners.

FG was known to several police forces and was served with a 7 -year prison sentence for Grievous Bodily Harm 9 years ago. This information was not shared with health practitioners but was known to social services and the police. Basic information about FG in health records was scant. This was reported to be because although the mother and children were patients of the health services involved, father was not. He was viewed as a parent, not a patient. The 0-19 service electronic recording system does not allow for a father's record to be raised routinely, with the result that there is little recorded information about fathers' health or social history.

The question of whether, had FG's information been shared with other agencies, and if it could have impacted on how health professionals assessed the family's needs was considered. The general view of all practitioners was that it would not have made a difference to their assessments.

FG had had no recent contacts with the police. Health Practitioners had fully assessed the family's current vulnerabilities and needs on their initial contacts. Midwives had checked with children's social care and their safeguarding leads following the Booking- In visit. The GP had discussed the family history and current needs with the Named GP for Safeguarding Children. There had been no current concerns about the family and no unmet need requiring referral to Children's Social Care or Early Help Services.

All patients are routinely asked about sensitive issues such as domestic abuse and drug misuse. The midwife asked MG routine questions of this nature at her ante-natal appointments at the hospital where she had the opportunity to see MG alone. The GP, who also had the opportunity to see MG alone at the surgery for the post-natal check asked the same routine questions about domestic abuse. MG did not disclose any problems.

The health visitor had communicated with her colleagues and knew that no concerns had been disclosed.

Because of the Covid-19 restrictions, the New Birth Visit was conducted via a telephone consultation. This type of contact did not allow for sensitive questions to be safely asked. The

health visitor was unable to safely ask routine questions about domestic abuse on subsequent home visits as FG was always present.

As a result of the Covid-19 restrictions, many parents are now both working from home, with less opportunity for either of them to speak confidentially to professionals.

However, research has evidence that questions about domestic abuse need to be asked at every opportunity to be effective. The average time that it takes victims to disclose is 2-3 years. (SafeLives 2020)

Learning Point

- To consider how, under current restrictions and changing home working patterns, front-line workers can ask difficult and sensitive questions to parents without increasing risk or generating a false picture.
- To consider how systems for recording information can be developed to include all relevant information about the whole family, including fathers.

Good Practice Point

- Health professionals made good use of supervision in the ante-natal period, to explore family need and safeguarding.
- Throughout the pregnancy and following Child G's birth, the family received an excellent level of contact including face to face contact from professionals despite the Covid-19 restrictions.
- There was continuity of health visitor for this family throughout with a good relationship and trust identified

2. Impact on Practice of cultural difference

The Cheshire Police records identified FG's ethnicity as being a traveller. Although it was apparent through discussion, that the health visitor and community mental health nurse were aware of his ethnicity, the midwife was not.

The midwifery service had recorded father's ethnicity as White British. There was no record of father's ethnicity on health visitor records. The 0-19 service electronic recording system does not allow for more than basic information about fathers to be routinely recorded.

Any ethnicity is an important factor in assessing need. In this case it was potentially important in respect of advice on feeding and care of young infants. The travelling community tends to choose formula feeding as their method of choice with the responsibility for caring for infants and young children firmly in the mother's domain. ('You likes your way, we got our own way' Gypsies and Travellers views on infant feeding and professional support: L. J.Condon, D.Salmon:2014)

Learning Point

- To consider how systems for recording ethnicity can reflect the cultural backgrounds across a whole family.

3. Assessment by adult facing services of impact of parental medication, mental health and other vulnerabilities on parenting

MG had been a client of the community mental health team for a considerable time. During the period of this review, she had had two community mental health workers. Both workers had a constructive and good relationship with both mother and father. They had an awareness of the whole family and the safeguarding agenda. The records showed there had been good observation of the children and their interaction with parents.

However, the observations did not lead to analysis of the impact of mother's fluctuating mental health on her own parenting role or how the additional stress could impact on father's parenting role and well-being. There was no re-assessment of whether the family and FG, particularly, could benefit from extra support through a referral to other services including the early help service. This was mirrored in GP and Health Visiting Records. The family circumstance had changed since their initial assessments. These changes were observed and recorded but there was no evidence of re-assessment of need.

During national Covid-19 Pandemic Lock-down, the family support service was not operating out of children's centres but had maintained a home visiting service. It is not clear whether adult facing services were aware of the family support service offer during lockdown. A referral to this service may have provided support for father who was a parent but not a client of the midwife, health visitor and community mental health worker.

Learning Point

- To consider how adult services, including mental health can understand how issues affecting adult vulnerability can impact on wider family and parenting and practitioners have a wider focus to reflect this
- To consider how to routinely review the use of early help services when family circumstances and vulnerabilities change
- All children's and adult's frontline services should know what the early help offer is during lockdown restrictions and be informed of any changes.

4. Agency curiosity

Although the family was clearly well known to the professionals involved, there were opportunities in which professional curiosity could have triggered a deeper exploration of the family circumstances.

These include questions about the family's wider social support network including who cared for SG1 whilst MG and FG were at maternity appointments and whether that person/people provided were able to provide social support for the family.

There was a request by MG to see her community mental health nurse away from the family home. MG attended the clinic appointment provided where she divulged some relationship problems with her partner. Professional curiosity may have prompted the practitioner to explore questions about domestic abuse and the safety of MG and the children.

MG's attended the baby clinic to have Child G weighed at the end of June. She had chosen to attend the clinic rather than have a home visit. Whilst at the clinic she pointed out 2 tiny marks on BG's

face. Tiny lesions such as this are not uncommon in small babies. The health visitor was very thorough in recording these marks, checking the baby for other lesions, and asking how they happened. MG suggested that it was possible that FG had accidently scratched the baby with his nail. This could easily be the case, but it was an opportunity for further exploration and advice, including curiosity about if and why MG was worried about them. The clinic health visitor saw the incident as significant enough to share with the family health visitor.

Learning Point

- To consider how to promote and explore professional curiosity through the use sensitive questioning and safeguarding supervision.

5. Research Evidence that ICON is effective and sits within a range of opportunities to give both Parents access to support when they are stressed with a baby

Cheshire East Public Health and Child Death Overview Panel initially adopted the ICON Programme as a response to local child deaths.

ICON is an evidence- based programme that provides information about infant crying and how to cope. The idea for the ICON programme and the different interventions within it was conceived by Dr Suzanne Smith PhD following a travel Fellowship to the USA and Canada in 2016 which included the study of effective interventions and research into the prevention of Abusive Head Trauma. Research suggests that some lose control when a baby's crying becomes too much. Some go on to shake a baby with devastating consequences. Previous serious case reviews nationally have asserted the evidence to support this view.

The ICON programme provides a simple message that supports parents/carers to cope with infant crying when it goes on for a long time.

Cheshire East has adopted a multi-agency roll out of the ICON Programme, which includes health services, children's social care, early help service, adult facing services and the police service. All front -line staff including police officers are actively using the programme. The programme includes roll out of information to both mothers and fathers and includes information on downloading an app for dads.

In addition, front-line staff working with children and families were provided with a timely update issued by NHS England and NHS Improvement promoting the use of ICON to prevent non-accidental injury to infants during the coronavirus pandemic. This message was initially aimed at midwives and re-iterated the use of the programme with fathers.

It was apparent when reviewing this case that the ICON Programme had become absorbed into the culture of working with families in Cheshire East. Child G's family had received all relevant information on this programme through the ante-natal and post-natal periods from a variety of different health professionals. FG was not, however, able to download the 'dadpad' as it is not currently available in Cheshire East.

Learning Point

- Consider the benefits of the use of the 'dadpad' in Cheshire East.

Good practice Point

- The use and multi-agency roll out of ICON in Cheshire East was triggered by the Child Death Overview Panel and Public Health in response to child death data. It is an excellent example of a multi-agency approach to having routine conversations with all families with infants and young children about managing crying in babies and raising awareness of the danger of rough handling or shaking infants.

6. Assessment of baby feeding and weight causing stress within family.

Child G was born premature at 36 weeks gestation. MG and FG were well supported by the health visitor and midwife in respect of infant feeding. BG was formula fed with both parents being involved. FG carried out the night feeds and MG reported he was 'better at getting the formula down than she was'.

Child G consistently gained weight and followed the 50th centile, corrected for age when charted by the health visitor on centile chart. However, at Child G's 8-week development check, the GP recorded her weight as being on the 3rd centile and asked the Health Visitor to carry out weekly weights. It is not clear whether the GP had corrected for age when plotting the weight on the centile chart. However, to avoid parents becoming anxious, professionals should have a universally accepted approach to recording weight for premature infants on centile charts.

Learning point

- All professionals to adopt a universal approach to recording weight for premature infants on centile chart.

Summary

The professionals involved with Child G and her family provided a good service and sensitive care in a difficult period of national lock-down due to the Covid-19 Pandemic. They communicated well with each other and had frequent contact with the family, including face to face contact. Although some areas of learning have been identified it is unlikely that professionals could have predicted or prevented Child G's death.

Summary of Learning

- To consider how, under current restrictions and changing home working patterns, front-line workers can ask difficult and sensitive questions to parents without increasing risk or generating a false picture.
- To consider how systems for recording information can be developed to include all relevant information about the whole family, including fathers.
- To consider how systems for recording ethnicity can reflect the cultural backgrounds across a whole family.
- To consider how adult services, including mental health can understand how issues affecting adult vulnerability can impact on wider family and parenting and practitioners have a wider focus to reflect this
- To consider how to routinely review the use of early help services when family circumstances and vulnerabilities change

- All children's and adult's frontline services should know what the early help offer is during lockdown restrictions and be informed of any changes.
- To consider how to promote and explore professional curiosity through the use of sensitive questioning and safeguarding supervision.
- Consider the benefits of the use of the 'dadpad' in Cheshire East.

Summary of Good Practice

- Health professionals made good use of supervision in the ante-natal period, to explore family need and safeguarding.
- Throughout the pregnancy and following Child G's birth, the family received an excellent level of contact including face to face contact from professionals despite the Covid-19 restrictions.
- There was continuity of health visitor for this family throughout with a good relationship and trust identified
- The use and multi-agency roll out of ICON in Cheshire East was triggered by the Child Death Overview Panel and Public Health in response to child death data. It is an excellent example of a multi-agency approach to a Public Health Initiative.

References

'You likes your way, we got our own way': Gypsies and Travellers' views on infant feeding and health professional support: Louise J Condon BA (hons) RGN RM HV diploma MSc PhD , Debra Salmon RGN BA (hons) HV diploma MSc PhD (2014)

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